NTSB National Transportation Safety Board

Collaboration: Safety Culture at the Industry Level

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The Contrast

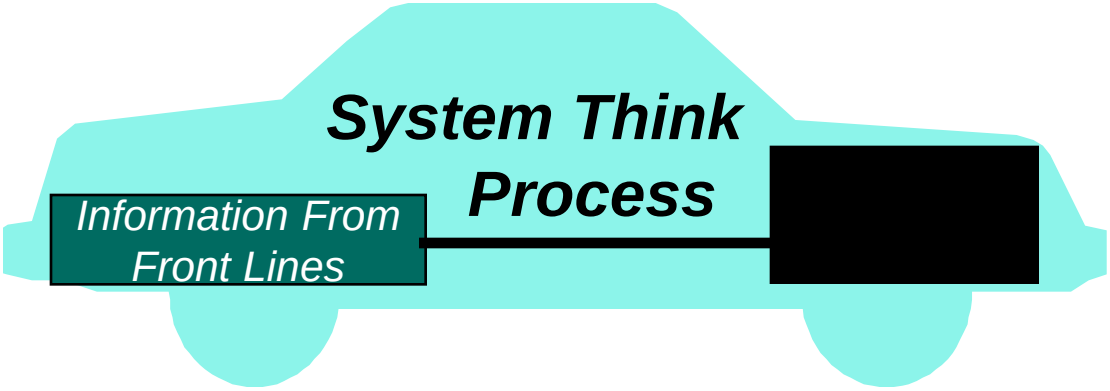
- Conventional Wisdom:

Improvements that improve safety
usually also reduce productivity

- Lesson Learned from Proactive Aviation Safety Programs:

Safety can be improved in a collaborative way that also results in *immediate productivity improvements*

Process Plus Fuel Creates a Win-Win



Improved *Safety*

AND

Improved *Productivity*

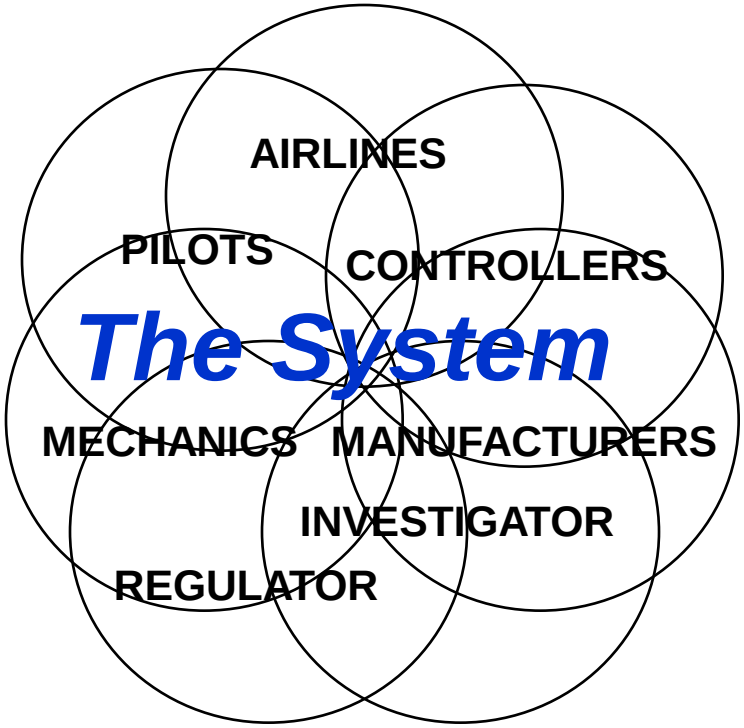
Outline

- The Challenge
- Collaboration Successes in Aviation
  - Industry Level
  - Manufacturer Level
- Roles of Leaders and Regulators
- Collaboration in Healthcare?

The Challenge: Increasing Complexity

- **More System *Interdependencies***
  - Large, complex, interactive system
  - Often tightly coupled
  - Hi-tech components
  - Continuous innovation
  - Ongoing evolution

- **Safety Issues Are More Likely to Involve *Interactions Between Parts of the System***



Effects of Increasing Complexity:

More "Human Error" Because

- System More Likely to be Error Prone
- Operators More Likely to Encounter Unanticipated Situations
- Operators More Likely to Encounter Situations in Which "By the Book" May Not Be Optimal ("workarounds")

The Result:

Front-Line Staff Who Are

- Highly Trained

- Competent

- Experienced,

-Trying to Do the Right Thing, and

- Proud of Doing It Well

. . . Yet They Still Commit

Inadvertent

Human Errors

The Solution: System Think

Understanding how a change in one subsystem of a complex system may affect other subsystems within that system

“System Think” via Collaboration

Bringing all parts of a complex system together to collaboratively

- **Identify potential issues**
- ***PRIORITIZE* the issues**
- **Develop solutions for the prioritized issues**
- **Evaluate whether the solutions are**
  - **Accomplishing the desired result, and**
  - **Not creating unintended consequences**

Major Paradigm Shift

How It Is Now . . .

You are highly trained

and

If you did as trained, you would not make mistakes

so

You weren't careful enough

so

You should be PUNISHED!

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the system allowed, or failed to accommodate, your mistake

and

Let's IMPROVE THE SYSTEM!

Objectives:

Make the System

(a) Less Error Prone

and

(b) More Error Tolerant

The Health Care Industry

To Err Is Human:

Building a Safer Health System

"The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system."

Institute of Medicine, Committee on Quality of Health Care in America, 1999

Major Source of Information: Hands-On "Front-Line" Employees

"We Knew About That Problem"

(and we knew it might hurt someone sooner or later)

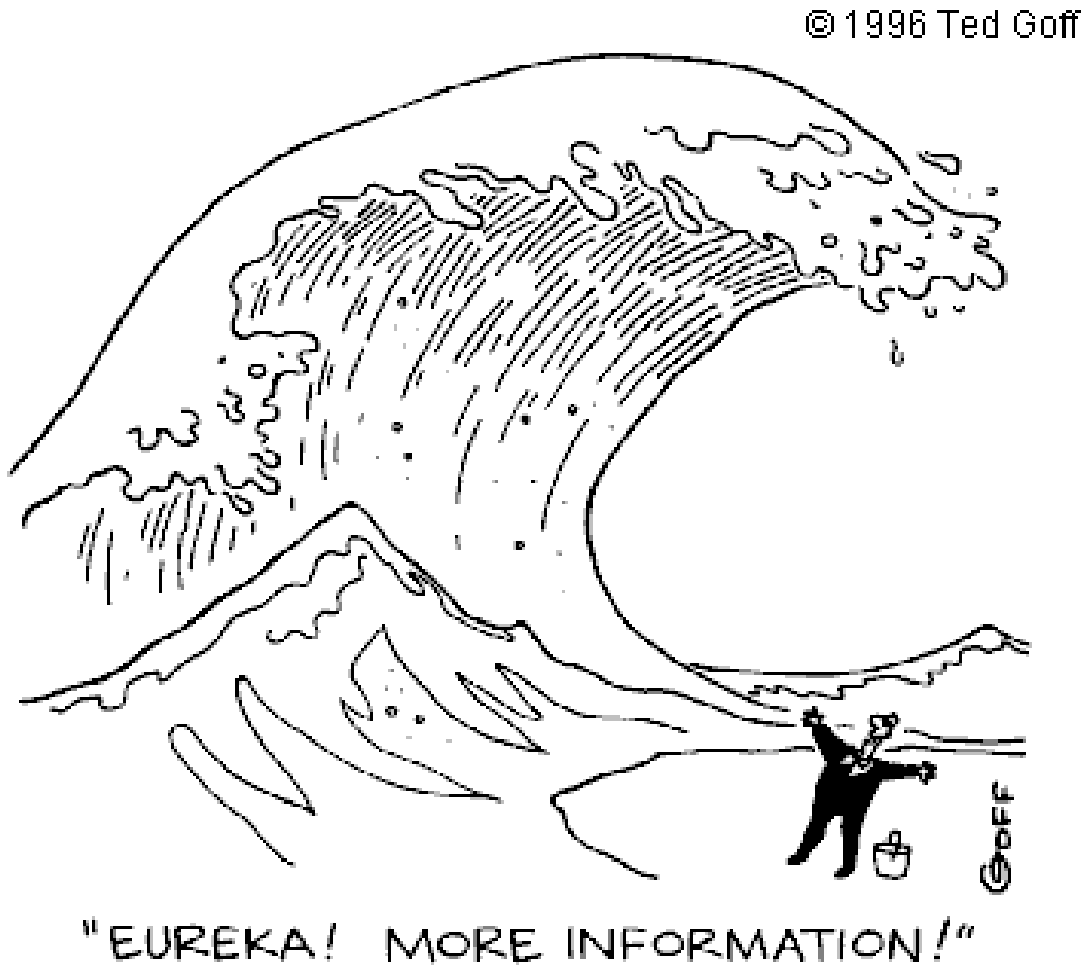
Next Challenge

Legal/Cultural Issues

Improved Analytical Tools

As we begin to get over the first hurdle, we must start working on the next one . . .

Information Overload



From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA

Analysts

Tools

Processes

USEFUL

INFORMATION

Smart Decisions

- **Identify issues**
- ***PRIORITIZE!!!***
- **Develop solutions**
- **Evaluate interventions**

Collaboration Success Story

65% Decrease **in Fatal Accident Rate, 1997 - 2007**

largely because of

System Think

fueled by

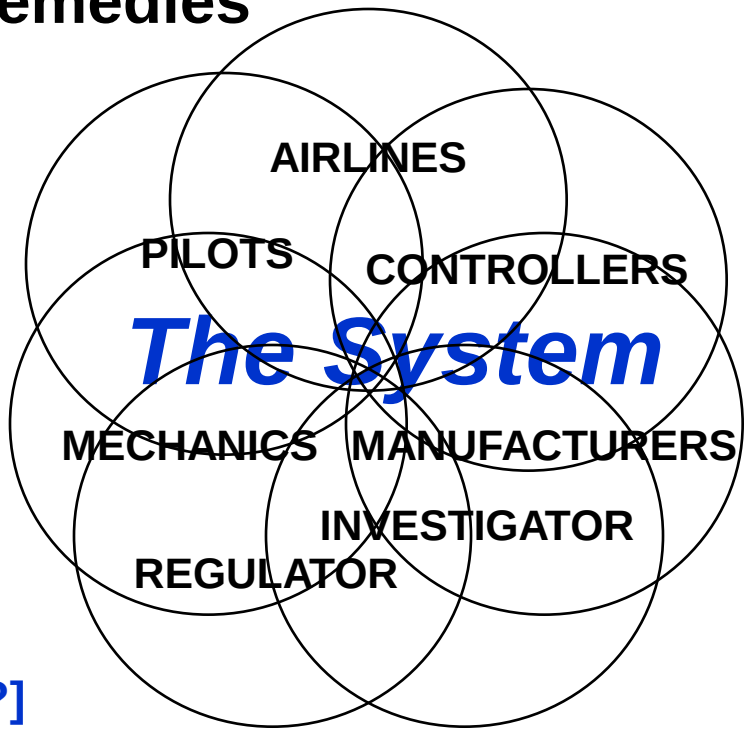
Proactive Safety Information Programs

P.S. Aviation was already considered *VERY SAFE* in 1997!!

Commercial Aviation Safety Team (CAST)

Engage *All* Participants In Identifying Problems and Developing and Evaluating Remedies

- Airlines
- Manufacturers
  - *With the systemwide effort*
  - *With their own end users*
- Air Traffic Organizations
- Labor
  - *Pilots*
  - *Mechanics*
  - *Air traffic controllers*
- Regulator(s) [Query: Investigator(s)?]



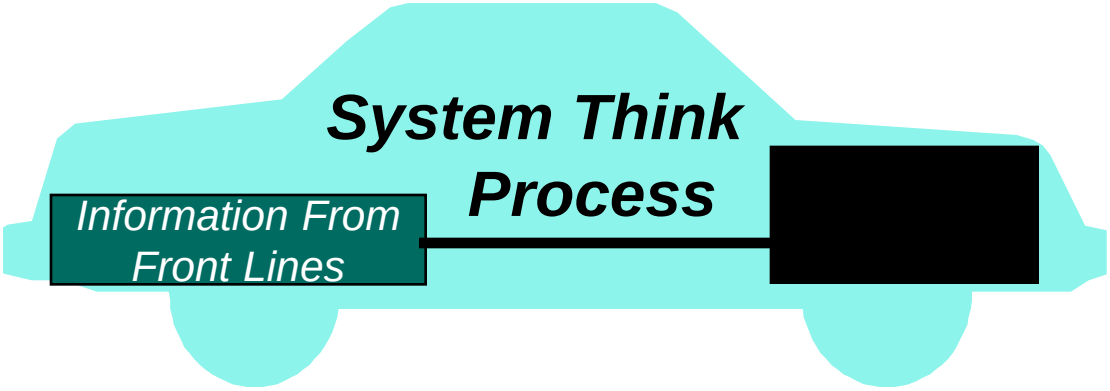
Another Major Paradigm Shift

- **Old: The regulator identifies a problem, develops solutions**
  - **Industry skeptical of regulator's understanding of the problem**
  - **Industry fights regulator's solution and/or implements it begrudgingly**
- **New: Collaborative "System Think"**
  - **All participants involved in identifying problem**
  - **Industry "buy-in" re interventions because everyone had input, everyone's interests considered**
  - **Prompt and willing implementation**
  - **Interventions evaluated . . . *and tweaked as needed***
  - **Solutions probably more effective and efficient**
  - **Unintended consequences much less likely**

Challenges of Collaboration

- **Human nature: "I'm doing great . . . *the problem is everyone else"***
- **Participants may have competing interests, e.g.,**
  - **Labor/management issues**
  - **May be potential co-defendants**
- **Regulator probably not welcome**
- **Not a democracy**
  - **Regulator must regulate**
- **Requires all to be willing, *in their enlightened self-interest,* to leave their "comfort zone" and think of the System**

Actually a Win-Win-Win



Improved
Safety

AND

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P.S. Collaboration also significantly reduces the likelihood of unintended consequences!

The Role of Leadership

- Demonstrate Safety Commitment . . .

But Acknowledge That Mistakes Will Happen

- Include "Us" (*e.g.*, System) Issues,

Not Just "You" (*e.g.*, Training) Issues

- Make Safety a Middle Management Metric

- Engage Labor Early

- Include the ***System*** --

Manufacturers, Operators, Regulator(s), and Others

- Encourage and Facilitate Reporting

- Provide ***Feedback***

- Provide Adequate ***Resources***

- ***Follow Through*** With Action

How The Regulator Can Help

- **Emphasize the importance of System issues *in addition to* *(not instead of)* worker issues**

- **Encourage and participate in industry-wide "System Think"**

- **Facilitate collection and analysis of information**
  - **Clarify and announce *policies for protecting information and those who provide it***
  - **Encourage other industry participants to do the same**

- **Recognize that *compliance* is very important, but the *mission is reducing systemic risk***

Collaboration at Other Levels?

- **Entire Industry**
- **Company (Some or All)**
- **Type of Activity**
- **Facility**
- **Team**

Manufacturer Level "System Think"

Aircraft manufacturers are increasingly seeking input, from the earliest phases of the design process, from

- ***Pilots*** **(*User* Friendly)**
- ***Mechanics*** **(*Maintenance* Friendly)**
- ***Air Traffic Services*** **(*System* Friendly)**

Suggestion for Healthcare

- **Select troublesome area**
  - **Nagging problem for many years**
  - **Many interventions have been tried, not successful**
  - **Likelihood that problems are systemic, not just people**
  - **Effort to address the system problems**
  - **Less defensiveness because not focused on single event**
- **Select collaborative corrective action group**
  - **All who have a hand in the process**
  - **Manufacturers?**
  - **Regulators?**
  - **Patients?**

Conclusion

- **System problems in complex systems generally necessitate system solutions**
- **Collaboration can facilitate the identification and resolution of problems in complex systems**
  - **Improve not only safety, but also productivity**
  - **Reduce the likelihood of unintended consequences**
- **To paraphrase James Reason, you can either swat mosquitoes forever or you can drain the swamp**

Thank You!!!

Questions?